the co-operators

CO-OPERATORS LIFE INSURANCE COMPANY
1920 COLLEGE AVENUE, REGINA, SASKATCHEWAN S4P 1C4

VISION CARE EXPENSE CLAIM FORM

INSTRUCTIONS

1. Employee/member fully complete Part 1.
2. Opthalmologist, Optometrist or Optician to complete Part 2.
3. Return completed form to your employer for completion of Part 3, **if employer's authorization is required.**
4. Attach original paid receipt with the completed form.
5. Please print.

Incomplete information can mean a delay in the processing. Please make sure everything is complete and accurate and original receipts are attached. Thank-you

ASSIGNMENT OF BENEFIT

I hereby assign my benefits payable from this claim to the named supplier and authorize payment directly to said supplier.

X _____
Employee's Signature

PART 1 EMPLOYEE/MEMBER

Group Policy No.	Account No.	PID #	Name of Employer/Policyholder

Employee/member: Last Name | First Name | Date of Birth (D/M/Y)

Mailing Address: Number - Street | New Address ❑ Yes ❑ No | Apt. No. | City | Province | Postal Code

Patient Name | Relationship ❑ Spouse ❑ Son ❑ Daughter ❑ other_____ | Date of Birth (D/M/Y) | Student ❑ Yes ❑ No Handicapped ❑ Yes ❑ No

1. Is this patient's first pair of glasses or contact lenses? ❑ Yes ❑ No If "No" give date of last purchase _____ (D M Y)
2. Are benefits payable from any other company/source? ❑ Yes ❑ No If "Yes" name source _____ Spouse's date of birth _____ (D M Y)
3. Do glasses, lenses, frames or contacts replace item(s) lost, broken or damaged? ❑ Yes ❑ No
4. Is this your first benefit claim with The Co-operators? ❑Yes ❑No
5. If patient is a student over the age 18, name of school _____. Student status: ❑ Full-time ❑ Part-time ❑ Correspondence, enrolled in the semester starting _____ (date) and ending _____(date). Will student be graduating at the end of the semester indicated? ❑ Yes ❑ No

I certify that the above information is true and correct to the best of my knowledge and authorize the release of all information regarding this claim to my insurer.

X _____ Employee's/Member's Signature

X _____ Date

PART 2 SUPPLIER STATEMENT — THIS SECTION MUST BE COMPLETED IN FULL

OPTICAL SUPPLIES Furnished to _____ Date Dispensed _____ Nature of Visual Defect _____

Is this first pair of glasses or contact lenses? ❑ Yes ❑ No If "No" did prescription change from previous one? ❑ Yes ❑ No

Please check items supplied ❑ Frames ❑ Glass/Plastic Lenses ❑ Contact Lenses ❑ Prescription or non prescription sunglasses.

If contact lenses were supplied, please complete the following:

Were lenses prescribed for sever corneal astignatism, severe corneal scarring, keratoconus, or aphakia? ❑ Yes ❑ No

Can visual acuity be improved to at least the 20/40 level by contact lenses? ❑ Yes ❑ No

Could visual acuity be improved to at least the 20/40 level by spectacle lenses? ❑ Yes ❑ No

CHARGES FOR MATERIALS SUPPLIED:

Frames	$
Lens for Right Eye	
Lens for Left Eye	
Hardex or Safety Lens	
Photo Gray or Tinting	
Dispensing Fee	
Other (Specify) _____	
Total	$

Name of prescribing Ophthalmologist or Optometrist

Name and Address of Supplier

Signature
X

Date | Telephone Number

PART 3 EMPLOYER/POLICYHOLDER

Employee's Effective Date (D/M/Y)	Dependant's Effective Date (D/M/Y)	Termination Date (D/M/Y) (If applicable)

Signature of Employer/Plan Administrator Official	Classification	Date
X		